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ABSTRACT

The paper reviews the training need by professionals in the allied health services for work with handicapped children and youth. The American Society of Allied Health Professionals (ASAHP) has conducted workshops in which roles and responsibilities for allied health personnel were identified, such as helping to coordinate health, education, and related services, and promoting interdisciplinary pre-service teaming opportunities. A recent forum explored ways to achieve collaboration in programs of allied health and education and identified barriers to such coordination (including communication problems, parochialism in professional training programs, and financial constraints). Policy recommendations were made on a national level (such as establishing a coalition among national associations), state level (including encouraging the analysis of data for training and service delivery needs), and local level (such as promoting formal agreement among service providers, local education agencies, and public and private agencies). A task force considered issues in the design of quality personnel preparation programs, resources, and data needs. (CL)

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MULTIDISCIPLINARY EDUCATION:

CORE COMPETENCIES FOR MEETING THE NEEDS OF YOUNGSTERS WITH DISABILITIES

by

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BACKGROUND

The Education for All Handicapped Children Act has existed for seven years; yet still today there are large numbers of American youngsters with handicapping conditions who are not receiving appropriate educational and related health services. While some allied health professionals (e.g., audiologists, occupational and physical therapists and speech-language pathologists) have long been involved in initiatives for children and youth with handicaps, most have not. The American Society of Allied Health Professions (ASAHP)* believes professionals who work in health-care settings have special access to the majority of these children, and can positively impact local, state and national efforts in identifying the unserved youngsters in this country and ensuring their referral to appropriate educational settings.

Supported by the Office of Special Education and Rehabilitative Services (OSERS), the Society was awarded a three-year grant in 1980 to involve allied health professionals in efforts to meet the education and education-related health needs of children with handicaps. ASAHP's promotion of "alliances in advocacy" has focused on <u>all</u> the related-health professions, not merely on those, like speech-language pathologists and physical therapists, whose work regularly involves persons with handicapping conditions. The Society's initiative has involved such others as physician and nurse assistants, dental hygienists, nurse midwives, dieticians, and medical records professionals whose health-care setting roles bring them into regular, often very early contact with children with handicaps. ASAHP recognizes all health professionals may not possess the technical expertise to assist clients, families, and/or friends with problems related to the needs of disabled youngsters; it also recognizes, however, as professionals in the health-care system, they will be perceived to possess such competence, and therefore, need to be prepared.

The Society is now nearing completion of its current project. The results of its work are most impressive, particularly in the design of curricula, instructional strategies, and advocacy models which encourage all allied health professionals to become actively involved in advocating for the rights and needs of youngsters with handicaps and their families. Significantly, outcomes of the project have pointed continually to the critical need for an integrated, coordinated service-delivery system composed of providers who view the youngster as a whole person with unique, life-long health and education needs. This paper examines the issues related to preparing personnel for their responsibilities in coordinating health and education services for the client and family.

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* Appendix B provides a profile of the American Society of Allied Health Professions (ASAHP).

MULTIDISCIPLINARY EDUCATION: CORE COMPETENCIES FOR MEETING THE NEEDS OF YOUNGSTERS WITH DISABILITIES

by

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The Education for All Handicapped Children Act of 1975 (Public Law 94-142) guarantees all children and youth with handicapping conditions the provision of a free and appropriate education in the least restrictive environment. The nation's ability to achieve this goal depends greatly on the human and fiscal resources available to meet the special education and related service needs of youngsters with handicapping conditions and the manner in which these resources are used. In passing PL 94-142, Congress intended that the resources made available to meet childrens' special needs would be employed in a maximally effective and cost-efficient manner.

Funding provided under the authority of PL 94-142 helped prepare related service and special education professionals to meet the new requirements imposed by the law. Additional resources also have been made available through the Department of Education to help prepare mainstream providers of education and health care (e.g., regular educators, pediatricians, family practice physicians, and a variety of allied health professionals) to recognize and meet the needs of youngsters with handicapping conditions. These projects have stimulated a professional awareness, concern, and creative action which previously existed only minimally. Much has been accomplished within the separate disciplines: in special education, in regular education, and in several related health professions, particularly speech-language pathology and audiology, occupational and physical therapy, and school nursing.

In spite of recent gains, however, current competition for limited resources at all levels of government demands the maximal, appropriate use of all available human and fiscal resources. More than ever, efficient, cost-effective coordination of health and education services must be provided if the accomplishments of the past seven years are not to be reversed.

Case after case of children and youth with handicaps or chronic illnesses clearly illustrate the need for coordinated service delivery mechanisms. In discussing a 3½ year old boy born with rubella syndrome, Barba (1977) cites thirteen agencies, clinics, and services providing care for the child and his family. Along with congenital heart disease and congenital cataracts, the child exhibited slow motor and mental development, blindness, hearing loss, and intolerance to milk. By 3½ years of age, this youngster and his family had interacted with medical, related health, and education professionals representing approximately twenty different professions.* Barba reports:

> . . .the family of this child is being run to death and has incurred considerable expenses despite multiple resources for assistance. Virturally, without a break, this mother has continuous appointments over two week periods. . . .
>
> This child has received regular follow-up for his various diagnostic problems. However, his family is run ragged and so near the end of its rope that they are considering institutional placement despite the inappropriateness of such placement. . . .
>
> Many of the services given this child grew. . . .Countless medical summaries and notes exist, but they are scattered in the records of several facilities (p.203).

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* Professionals serving this child could include: pediatrician. psychologist, social worker, nurses, ophthalmologist, allergist, audiologist, otolaryngologist, speech-language pathologist, pediatric neurologist, occupational therapist, learning disabilities specialist, special education teacher, nutritionist, clinical laboratory practioners, cardiologist, physical therapist, optometrist, medical assistants, and medical record administrators.

This "patchwork" of narrowly focused approaches to service delivery, which tend to be based on age, disease or handicap classification, income, political jurisdiction, and specialization of the service provider, "multiplied by millions is an estimate of the cost in lives, energy, and effort that is spent with, in many instances, no gain for the. . .individual, his family, and society" (Barba, 1977, p. 203).

While specialized services are needed to meet the needs of persons with handicaps and their families, the professional parochialism or "narcissism" (Bashir, 1982) which has accompanied the growth of specialized services has supported inefficiencies in the delivery of services, including duplication of services, wasted resources, and competition among providers (Helge, 1981). Professional parochialism, which permeates the delivery system, generates additional barriers to cost-effective, quality care, including:

- Communication problems and mistrust among professionals, between professionals, youngsters, and their parents, and between and among programs, departments, and agencies;
- Lack of knowledge related to all handicapping conditions and other professionals' roles in serving persons with handicaps, thus promoting inappropriate diagnostic, case management, and instructional strategies;
- Maintenance of perjorative attitudes towards younsters with disabilities; and
- Disparity in treatment, programmatic, and financial priorities (Del Polito, 1982).

To alleviate these barriers and inadequacies in the provision of education and health services to youngsters with handicaps, leaders in education and health care are calling for needed revisions in training programs which will prepare all service providers (health and education alike) to provide integrated, coordinated services adapted to the unique, life-long needs of the youngsters with handicapping conditions.

This paper will review the curricular and training needs of professionals serving these youngsters and their families, with relevant data presented from a major initiative of the American Society of Allied Health Professions (ASAHP) in building alliances in advocacy for children and youth with handicapping conditions.

In Regional Workshops conducted across the country by ASAHP for cadres of experienced allied health professionals,* participants identified specific roles and responsibilities all allied health professionals should assume--whether or not they interacted directly or consistently with younsters who have disabling conditions. Appendix A contains a complete listing of the roles and responsibilities; among those repeatedly emerging, however, were those addressing collaboration among health and education professionals. Specifically, to:

1. Help coordinate efforts of health, education, and related services;
2. Understand other health, education, and related service professionals' roles;
3. Work cooperatively with other professionals concerned with the services provided for children and youth;
4. Actively participate in coordinated and adaptive health-care planning for the life span of the youngsters;
5. Promote excellence in the quality of service delivery among one's own and others' professions;
6. Promote interdisciplinary pre-service teaming opportunities; and
7. Promote advocacy initiatives on behalf of youngsters with other professionals.

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* Regional workshops were conducted in California, Minnesota, Maryland, Vermont, Tennessee, and Colorado. Individuals participating in workshops have represented the professions of Audiology/Speech-Language Pathology, Corrective Therapy, Dental Assistance and Dental Hygiene, Dietetics, Health Record Administration, Rehabilitation Counseling, Social Work, Nutrition, Occupational Therapy, Physical Therapy, Nursing, Physician Assistance, Psychology, and Recreational Therapy.

In the recent Workshop on "Children with Handicaps and their Families" sponsored by Surgeon General Everett C. Koop (December, 1982), similar issues and needs surfaced. Along with the recommendation for more cost-effective, integrated services, the 120 invited participants emphasized the need for "addressing standards and quality assurance, including incorporating education in the disability areas in the curricula of health professionals" (Hendrick, 1983, p.2).

While a few training programs in allied health address these issues, most do not. Leaders of the related health professions generally recognize the lack of training their students receive to prepare them for meeting their responsibilities for youngsters with handicapping conditions. Further substantiation has come directly from practitioners across the country (Del Polito, 1982a). They concur with and reinforce ASAHP's underlying position and the foundation of this paper: related health professionals, including those working in health-care settings, possess (a) special access to children and youth with handicapping conditions; and (b) little, if any, preparation for meeting their roles and responsibilities to assure these youngsters obtain appropriate educational services.

Similar calls for collaborative training emerge in documents prepared by and for special and regular educators (Stedman, 1983; Anastasiow, 1981). The revised National Council for Accreditation of Teacher Education (NCATE) Standards (1982) as well as materials prepared for the U.S. Department of Education's Division of Personnel

Preparation, Special Education Programs (DPP/SEP)--e.g., the National Inservice Network (NIN),* the Dean's Grants Project (DGP),** and the National Support Systems Project (NSSP)***--provide additional support for increased interdisciplinary approaches for preparing professionals who will work in multidisciplinary systems serving youngsters with handicapping conditions.

> This concern has been underscored by a state-by-state survey on problems in manpower supply, demand, and quality, undertaken for the Institute for the Study of Exceptional Children and Youth at the University of Maryland. . . . Preliminary findings have shown that the lack of integrated preparation among and between educators and allied professionals, and their subsequent difficulties with collaboration and teamwork in schools and agencies, is a significant problem across the country (Smith-Davis, 1983).

A dilemma exists. Allied health, regular education, and special education professionals require training programs which emphasize interdisciplinary teaming approaches both in curricula and in field experiences. Severe problems surface, however, when schools and programs attempt to coordinate personnel preparation programs across these three professions.

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* The National Inservice Network (NIN) established a network of inservice providers concerned with assisting regular educators resolve problems and issues related to educating students with handicaps in their classrooms.

** Dean's Grants are awarded competively to Deans of teacher education training programs to initiate curricular revisions in teacher-preparation programs to ensure graduates would be prepared to meet the needs of students with handicaps in regular schools and classrooms.

*** The National Support Systems Projects was funded to serve Dean's Grant institutions in a diversity of areas, including technical assistance activities, developmental efforts, and dissemination initiatives.

Coordination issues and recommendations for future collaboration among the allied health and education professions were addressed in a national invitational forum sponsored by ASAHP in cooperation with the American Association of Colleges for Teacher Education (AACTE) in March 1982. The two-day forum, "Alliances in Health and Education for Disabled Children and Youth: Directions for the 80's," brought together chief administrators in allied health and teacher education training programs to explore the health and educational needs and the rights of both youngsters with disabilities and their families as they relate to personnel preparation.

Specifically, teams of chief administrators from one institution or community joined with teams from other parts of the country to explore:

- Trends in Allied Health and Education for Meeting the Needs of Disabled Youngsters and Their Families;
- Strategies for Improving the Quality of Personnel Preparation to Meet New Roles and Responsibilities;
- Implications for Developing Cooperative Programs in Allied Health and Education; and
- Strategies for Building Alliances and Creating New Organization Patterns for Cooperative Programs.

Forum participants included 125 deans and directors of allied health, teacher education, and medical training programs, as well as other administrators responsible for curriculum development and program coordination, and representatives from state and federal health and education agencies. Throughout the Forum's deliberations, collaboration in personnel preparation training programs was emphasized as an essential ingredient for addressing the inadequacies of the service delivery system and meeting the needs of youngsters with handicapping conditions. To achieve appropriate collaboration between schools

and programs of allied health and education, Forum participants identified the need for new and refocused leadership in building and implementing collaborative models for cooperation--among professions, among academic programs, and among institutions and agencies. The remainder of this paper will report on the major barriers to inter-professional and inter-agency alliances as well as the policy recommendations emerging from the Forum's problem-solving sessions. Finally, the author will report on the progress of the Society and the Society-coordinated Interdisciplinary Task Force (representing approximately fifteen health and education professional associations) in implementing and promoting the Forum's recommendations.

BARRIERS TO COORDINATION

The following lists the major barriers to inter-professional and inter-agency alliances identified by the 125 Forum participants working in small group sessions.

A. Communication problems between and among professional groups, academic units, educators, service providers, consumers, and advocates: including:

   1. Philosophical differences (e.g., discipline based vs. systemic approaches); and
   2. Complexity of institutions and institutional types.

B. Parochialism in professional training programs; including:

   1. Traditional missions and roles of various training programs and faculty;
   2. Emphasis on skill acquisition vs. philosophical and problem-solving approaches;
   3. Absences of common clinical settings for training; isolation of service delivery sites;
   4. Maintenance of traditional territorial specialization; and
   5. Fragmentation of service delivery and responsibility.

C. Low priority given to interdisciplinary activity in academic institutions; including:
   1. Little recognition among many programs/institutions that a problem related to coordination among health and education training programs actually exists;
   2. History of separateness between health and education, both physically and philosophically;
   3. Few university mechanisms available which facilitate or reward interdisciplinary activity; in fact, many interfere (e.g., negative impact of joint appointments for faculty tenure decisions and program accountability (FTE's);
   4. Credentialing and licensure procedures which mandate specialization and, therefore, weaken inter-professional activities;
   5. Competition for time and space in already over-packed curricula for students and faculty; and
   6. Perceptions of limited resources.

D. Financial constraints, including:

1. Lack of funding for training and service delivery, producing competition among the training and service delivery institutions for available resources;
2. Funding and control of related services by agencies separate from education agencies (e.g., occupational therapists funded by State Health Department); and
3. Influence of third-party payment eligibility for practice and health care delivery intervention.

E. Parochialism in service delivery (i.e., no one accepts responsibility for the whole person),including:

1. Perceived fragmentation of responsibility for the provision of services--among agencies and among professionals;
2. Limited incentives for interdisciplinary approaches;
3. "Turf" disputes;
4. Limited appreciation of each professional's expertise or contribution in the management of the youngster;
5. Conflicts in agreeing on who will make management decisions and coordinate the youngster's program;
6. Failure to prioritize service needs; and
7. Difficulty in recognizing each others' perspective relative to the child's (e.g., a physical therapist can explain what he/she is doing for the child but may not recognize or address the classroom teacher's needs in managing the same child).

F. Leadership issues, including:

1. Absence of a shared philosophy among leaders within and across professional groups; and
2. Absence of effective coalitions within the groups to influence policy and administrative decision making.

G. Governmental and regulatory issues, including:

1. Differences between the social/political realities of academia as compared to the social/political realities of service delivery practice;
2. Influence of accreditation regulations of professional societies on inter-agency collaboration and cooperation among professionals;
3. Influence of tenure and promotional regulations and institutional rewards systems for cooperation and interdisciplinary programs for preparing professionals; and
4. Influence of the disjuntive and incremental development of policy and regulations governing resources and services for a comprehensive policy for persons with handicapping conditions.

As key innovators within the health care and educational system, chief administrators in allied health and teacher education have much to contribute to the design and implementation of local, state, and national initiatives for youngsters with disabilities, their families, and their service providers. The policy recommendations emerging from the Forum's problem-solving sessions and the preamble, repeated here, clearly illustrate the collective vision maintained by the 125 participants. This vision encourages, guides, and supports new collaborative initiatives and models for personnel training programs.

Preamble

We believe the goal of education is to prepare each individual to function effectively and productively as a self-sufficient and contributing member of the sociey. Provision of an appropriate education becomes a key principle upon which educational programs are developed. It is important, therefore, to:

1. Provide a comprehensive and coordinated system of services to children and youth with handicapping conditions;

2. Coordinate and share responsibilities among the allied health, regular education, and special education professions for planning and delivering services;

3. Develop new coalitions among local, state and federal agencies, the private sector, colleges and universities, and professional organizations for developing education and health care delivery programs which are based upon a strong, comprehensive policy and are supported by adequate resources (financial, personnel, etc.) for meeting the needs of persons with handicapping conditions;

4. Disseminate successful and cost-effective models of service delivery to service agencies, educational institutions, and the public;

5. Develop new and stronger alliances among governmental agencies, advocacy groups, families, clients, educators, and the allied health professions for implementing effective models and other successful practices;

6. Increase the awareness of the various publics as well as members of the education and related health services professions to the needs of children and youth with handicapping conditions; and

7. Encourage and facilitate university systems to (a) examine critically the roles and responsibilities of education and health care providers for meeting the needs of youngsters with disabilities, and (b) develop appropriate curricula for personnel preparation programs to address the expanding roles and responsibilities.

A. National Recommendations

1. Promote a national priority for education and health alliances for children and youth with disabilities.

2. Establish a coalition among national associations and disciplines to (a) identify and utilize functional models of training and service delivery, and (b) promote alliances among the disciplines, professional associations, and federal agencies.

3. Advocate for the maintenance of strong federal legislation on behalf of individuals with disabilities and their families. A uniform policy for all states is essential if persons with handicapping conditions are to have adequate educational and health care services.

4. Advocate for the provision of adequate funding for implementing federal legislation and regulations.

More specific recommendations include:

5. Through ASAHP's Interdisciplinary Task Force, with representatives from national professional associations concerned with meeting the needs and rights of youngsters with disabilities, (e.g. American Society of Allied Health Professions, American Association of Colleges for Teacher Education, Council for Exceptional Children and other appropriate allied health, education, and medical professional organizations, as well as parent and consumer organizations), the following agenda items should be pursued:

   (a) Encourage professional associations to adopt policies and/or endorse positions supporting interdisciplinary education, training, and service delivery for persons with disabilities.

   (b) Assist interested individuals (at local and state levels) in instituting specific efforts for interdisciplinary training (pre-service and in-service).

(c) Identify and disseminate information on effective interdisciplinary models and programs via existing avenues (e.g., national and state association journals, newsletters, meetings, ASAHP's expertise exchange, etc.).

(d) Promote administrative support for interdepartmental cooperative efforts in educating allied health and education professionals (e.g., invite ASAHP, AACTE, CEC, and perhaps others to write a joint letter to appropriate chief administrators in allied health and teacher education training programs, emphasizing the importance of such interdepartmental cooperative training efforts; OSERS Deans Grant's research and models should be consulted as well).

(e) Develop and disseminate a brochure illustrating interdisciplinary management of services (rather than a particular profession's isolated contribution). The design and dissemination of the brochure should involve all appropriate professions.

(f) Promote the recruitment of individuals with handicapping conditions into the various professions.

(g) Promote research on efficient, cost-effective approaches to training and delivery of services.

(h) Promote the need for each profession to develop and/or maintain a comprehensive plan to raise consciousness among members of the professions about the needs and rights of individuals with disabilities.

(i) Promote compatible theoretical bases among the professions--or at least an understanding of other professions' theoretical bases.

(j) Promote an appreciation (recognition of and respect for) and an understanding of the competencies and roles of other disciplines through training institutions, state agencies, and professional organizations.

(k) Obtain sanctions and commitments from gate keepers in educational adminstration and professional associations in working toward the goals identified in the Forum.

B. State Recommendations

1. Work with state legislators to formulate strong, state-supported policies to assist youngsters with disabilities (ages 0-21) and their families.

2. Promote the establishment of formal agreements among those responsible for providing services to children and youth with handicapping conditions, including local education agencies, state agencies, regional boards, reimbursement agencies, and academic institutions to ensure coordinated, comprehensive, and appropriate plans for (a) the delivery of education and related health care services, and (b) preparing service providers.

3. Encourage states to gather, analyze, and disseminate data, including needs assessment information, for training and service delivery needs.

4. Encourage institutions to design appropriate curricula to prepare administrators of health and education programs for managing and coordinating comprehensive systems of service delivery.

5. Encourage states to establish certification requirements (or similar standards) which mandate adequate and appropriate preparation requirements for all persons serving children and youth in schools; i.e., regular teachers, special education personnel, and allied health personnel.

More specifically:

6. Encourage interdisciplinary and comprehensive planning among agencies providing education and related health services by convening a meeting of the agencies' key administrators at both state and local levels.

C. Local Recommendations (Note: Many of the National and State Recommendations also are appropriate for implementation at the local level.)

1. Encourage collaboration and develop new coalitions within academia (both between and among disciplines and institutions) and across systems (between and among public sector, private sector, academia, parent and consumer groups, employers, and legislative and regulatory bodies).

2. Encourage and promote formal agreements among the providers of services, local education agencies, and public and private agencies to ensure appropriate services for education, health care, and other life needs for children and youth with disabilities.

3. Promote the delivery of education and health-related services which are based according to locally coordinated and comprehensive plans.

4. Promote and develop appropriate conditions for professional practice for all health and education personnel.

5. Revise curricula to reflect the expanding roles and responsibilities of health and education professionals to meet the needs of youngsters with disabilities and their families, that is, curricula should be revised to include:

   a. Content and instructional strategies to produce health and education professionals who can interface with one another to serve the youngsters with whom they mutually interact.

   b. Core curricula across disciplines, including greater emphasis on: (1) communication and decision-making skills, (2) ethics; (3) laws and regulations; (4) individual rights; and (5) organizational and community resources.

   c. Strategies to facilitate interaction among faculty, students, clients, and professions for program decision-making, planning, and implementation.

   d. Shared training and practice opportunities among disciplines.

   e. New content areas (e.g., psychology of human sexuality, interpersonal and small group communication, organizational/systems change strategies, etc.)

   f. New technologies to demonstrate interdisciplinary activity.

6. Encourage and promote acceptance of a shared philosophical approach for service delivery and training among the professions (e.g., a philosophy which centers upon needs of the client).

7. Facilitate and develop new organizational arrangements within and among academic institutions and programs to:

   a. Include clinical faculty on academic curriculum committees;
   b. Include consumers, advocates, and employers in program planning;
   c. Facilitate faculty exchanges; i.e., academic, clinical, and school-based faculty;
   d. Formalize information sharing between disciplines and institutions;
   e. Provide continuing education opportunities for health and education professionals to meet their expanding roles and responsibilities; and
   f. Design an action plan which would include:
      - a needs assessment;
      - review of existing curricula;
      - review of clinical practice and field sites and placement;
      - review of philosophy and mission statements of professional programs to reflect current needs for <u>appropriate</u> practice;
      - review of local resources; and
      - develop collaborative initiatives among the health and education professions.

To implement the preceding national, state, and local policy recommendations, Forum participants urged the American Society of Allied Health Professions (ASAHP) to continue its leadership role, expanding on the work accomplished thus far, and establish an Interdisciplinary Task Force to (a) review the Forum's outcomes and (b) identify next steps to promote and implement the Forum's recommendations on behalf of youngsters with disabilities and their families. ASAHP's Board of Directors approved the establishment of such a Task Force and identified members and organizations for participation in the Task Force. A meeting of the Task Force was held January 27-28, 1983 in Washington, D.C. Members include representatives from the following:

- American Society of Allied Health Professions (ASAHP)
- American Academy of Pediatrics (AAP)
- American Association of Colleges for Teacher Education (AACTE)
- American Association of Community and Junior Colleges (AACJC)
- American Association of School Administrators (AASA)
- Council for Exceptional Children (CEC)
- National Association for Protection and Advocacy (NAPA)
- National Association of State Directors of Special Education (NASDSE)
- National Council on Developmental Dissabilities (NCDD)
- Parent Coalitions
- University Affliated Facilities (UAF)
- Education in Allied Health
- Education in Medicine
- Education in Special Education

In its deliberations, the Task Force focused on the critical issues in the design of quality personnel preparation programs, resources, and data needs, and identified future directions to meet the service delivery demands of the 1980s. Importantly, Task Force members reitterated and emphasized the need for interdisciplinary training and collaboration among allied health, regular education, and special education with the CHILD as the focus for all provision of services.

As Task Force members poignantly reviewed, professionals in health and education are unaware of one another's roles and responsibilities in providing services to youngsters with handicapping conditions:

- Related services professionals (e.g., PTs and OTs) meet for the first time over the body of the youngster with a handicap.
- Related services professionals and educators meet for the first time over the mind of the youngster with a handicap.

Exposure to others' roles is not included/available in training programs, with "ground rules worked out in the mainstream. . . .It's a national crime" (Ellis).

Collaborative, interdisciplinary training programs which address the concerns identified in this paper do exist; however, dissemination of effective practices and wide-spread implementation do not exist. Task Force members cited the critical need to:

1. Identify, document, and disseminate current model programs and practices;
2. Promote research to obtain the quantitative and qualitative data required to support "quality" training programs; and
3. Encourage and promote collaboration among all existing training programs preparing service providers in allied health, regular education, and special education.

The following summarizes, in outline form, the Task Force's deliberations on (1) criteria for quality training programs; (2) data needs; and (3) outcomes and future directions.

I. CRITERIA FOR QUALITY TRAINING PROGRAMS. These criteria were considered essential for all training programs preparing service providers (allied health, regular education, and special education providers) for their expanding roles and responsibilities for youngsters with handicaps and their families.

A. Program Design:

- Functionally-based: focused on the needs of the child and family.
- Interdisciplinary: pre-service, practicum, and in-service programs designed collaboratively by allied health, regular education, and special education.
- Community-based: designed collaboratively with local education and social service agencies, higher education institutions, clients, and families.

B. Curriculum Content:

- The education, related health, and psycho-social needs of the youngsters with handicapping conditions and their families.
- Attitudes: toward persons with disabilities, toward other professionals, and toward collaboration in the delivery of health and education services.
- Role definition and delineation; complimentary and individual professional responsibilities and practices for youngsters with disabilities and their families.
- Interdisciplinary team and case management responsibilities in planning for the life-span of the youngster.
- Governance, monitary, and informal control systems of local and state education and social service agencies.
- Advocacy responsibilities and rights as professionals in health and education.
- Realistic practicum experiences, with competent, model faculty and practicum supervisors.

C. Trainee Population:

- Special Educators
- Regular Educators
  - Elementary
  - Secondary
  - Vocational

- Allied Health Professionals
  - Occupational Tharapists
  - Physical Therapists
  - Audiologists and Speech-Language Pathologists
  - Rehabilitation Counselors
  - Nutritionists and Dietitians
  - Corrective Therapists
  - Social Workers
  - Physician Assistants
  - School and Clinical Psychologists
  - Recreational Therapists
  - Child-Life Specialists

  (NOTE: All related health professionals should be aware of their advocacy responsibilities as professionals in the health care system.)

- Medical Professionals
  - Nurses (school, clinical, and community-based nurses)
  - Pediatricians
  - Family Practice Physicians

II. DATA NEEDS. Members identified specific limitations in our current knowledge base which need to be addressed to design "quality" training programs responsive to the needs of youngsters with handicaps and their families. Quantitative and qualitative data are needed to determine:

A. Funtional needs of youngsters with handicapping conditions and their families to determine:

- Protocol/Clinical Practices
- Appropriate/necessary services
- Appropriate providers of services
- Credentialling needs
- Duplication and limitations of services

(Example: For Functional Need X, the youngster may require the Services of Provider A and B or C independently.)

B. Types and "effectiveness" of interdisciplinary and profession-specific (a) training programs, (b) practice, and (c) service delivery.

C. Supply and demand data for health and education services.

D. Definitions and delineations of "related services," "education," and "medical" services.

E. Competencies and skills required of health and education professionals to determine need for and impact on all levels and forms of training: technical schools, community and junior colleges, four-year programs, and graduate and post graduate programs.

F. Financial implications of service delivery mechanisms for local and state education and social service agencies.

III. OUTCOMES AND FUTURE DIRECTIONS. Members identified (a) specific outcomes for a national effort in designing quality personnel preparation programs in allied health, regular education, and special education, and (b) specific, limited activities to be conducted during the remaining three months of the Allied Health Child-Find and Advocacy Project by the American Society of Allied Health Professions (ASAHP).

A. National Effort

- Promote policy statements by professional organizations which identify:

  (1) Professionals' rights and responsibilities as explicit extensions of PL 94-142 and Section 504 of the Rehabilitation Act (i.e., what constitutes appropriate professional responsibility); and

  (2) Clear description of professional advocacy role (i.e., what constitutes appropriate advocacy).

- Design and obtain funding for demonstration efforts in interdisciplinary personnel preparation designed in compliance with the Task Force recommendations herein. Capitalize on national alliance concept by identifying alliance teams and coordinators at ASAHP/AACTE member institutions.

- Design, promote, and support coordinated training and service delivery with local and state education and social service institutions and agencies. Emphasize continually the functional needs of the client.

- Design, promote, and support public commitment activities among all appropriate constituencies for effective, coordinated training and service delivery for youngsters with handicaps and their families.

B. ASAHP Effort

- Develop a bold Policy Statement reflecting ASAHP's commitment to interdisciplinary training programs and service delivery in allied health, regular education, and special education.

- Develop a White Paper to support and expand ASAHP's policy statement on professional training and practice for meeting the needs of youngsters with handicaps and their families. The White Paper should emphasize the professional, economic, and practical implications of interdisciplinary training and service delivery in health and education.

- Disseminate ASAHP's Policy Statement and accompanying White Paper to all appropriate local, state, and national professional organizations, agencies, and higher education institutions for acceptance, support, and use with their constituencies.

  For example, allied health and education trainers will be able to use the documents for designing and supporting new programs, as well as for use with students in class discussions.

- Plan a keynote panel program for ASAHP's annual meeting, showcasing model interdisciplinary training programs. Invite Task Force members to participate.

- Coordinate data collection and dissemination of interdisciplinary personnel preparation programs through the Society's Center for Continuing Education.

As evidenced throughout this paper, efficient, cost-effective, quality care for persons with disabilities and chronic illnesses is jeopardized by the lack of coordination of health and education services. For personnel preparation programs, the implications are clear: while many times difficult to initiate and maintain, interdisciplinary, collaborative training approaches (pre-service, practicum, and in-service) must be embraced and promoted by professional organizations, credentialling bodies, and most importantly, by those educating our providers of services in the 1980s.

Readers comments, suggestions, and recommendations regarding the contents of this paper are most welcomed. Please forward reactions to:

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AMERICAN SOCIETY OF ALLIED HEALTH PROFESSIONS

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APPENDIX A

ROLES AND RESPONSIBILITIES OF ALLIED HEALTH PROFESSIONALS IN PROVIDING SERVICES TO INDIVIDUALS WITH DISABILITIES AND THEIR FAMILIES

. . .
Let it be a son, a son, said
the man in the driving mirror,
Let it be a son . . .

At seven-thirty
the visitors' bell
scissored the calm
of the corridors,
The doctor walked with me
to the slicing doors.

His hand upon my arm,
his voice — I have to tell
you — set another bell
beating in my head:
your son is a mongol
the doctor said. . . . .

from "The Almond Tree"
by John Stallworthy*

A child is born with a disability. Where, when and how do service providers in allied health enter the picture? As professionals or as concerned citizens and neighbors, what assistance or interventions can allied health professionals provide the parents and the child to ensure the child moves through the educational and related health services maze and is educated appropriately to lead the fullest and most productive life possible? What preparation do service providers need to fulfill their professional (and personal) roles and responsibilities for youngsters with disabilities and their families?

Supported by the U.S. Department of Education's Office of Special Education and Rehabilitative Services, the American Society of Allied Health Professions (ASAHP) initiated a national project to address these and other questions related to a major policy concern affecting the Allied Health professions; i.e., facilitating alliances among the allied health professions in efforts to meet the education and related health needs of youngsters with disabilities. The funding was made possible by the Education for All Handicapped Children Act of 1975 (PL 94-142), mandating the provision of free and appropriate educational services for all handicapped children and youth between the ages of 3 and 21.

* From The Astronomy of Love, Oxford University Press, 1961.

While the legislation has existed for six years, there are still large numbers of American youngsters with handicapping conditions who are not receiving appropriate services. ASAHP believes -- and the Office of Special Education concurs--allied health professionals, including those who work in health-care settings, have special access to the majority of these children and the systems which serve them and can impact positively local, state, and national efforts in identifying and referring unserved handicapped children and youth--and in advocating in their behalf.

The Society's promotion of "Alliances in Advocacy for Disabled Children and Youth" has focused on all the related-health professions. ASAHP recognizes that while all allied health professionals may not possess the technical expertise to assist clients, families, and/or friends with problems related to the educational and health-related needs of disabled youngsters, as professionals in the health-care system they will be perceived to possess such competence, and therefore, need to be prepared.

The challenge of the ASAHP's Advocacy Initiative, therefore, has been to design curricula, instructional strategies, and advocacy models which encourage all allied health professionals and their educational institutions and professional associations to become involved in promoting the rights and needs of disabled youngsters and their families. Advocacy, as defined for the Project (i.e., facilitating a continuum of services--from listening to the needs and concerns of the disabled youngster to designing and implementing legislation on his/her behalf) stresses the importance of allied health professionals' understanding of (a) the needs and rights of youngsters with disabilities, (b) referral sources and strategies, and (c) advocacy skills and strategies.

A major activity of the Advocacy Initiative for Disabled Persons has been the implementation of regional workshops, designed for cadres of experienced allied health professionals in each of the Department of Education regions. Participants for each of the six workshops* were identified by their professional organizations as leaders within their professions and targeted for their unique potential in affecting change both within and outside their work environments. In addition to the significant professional and personal alliances and advocacy initiatives developed during the workshops, a major outcome was the identification of specific roles and responsibilities all allied health professionals should assume--whether or not they interact directly or consistently with youngsters who have disabling conditions. Importantly, the roles and responsibilities reported below emerged repeatedly across working groups and across regions.**

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*Regional workshops were conducted in California, Minnesota, Maryland, Vermont, Tennessee, and Colorado.

**Individuals participating in the workshops have represented the professions of Audiology/Speech-Language Pathology, Corrective Therapy, Dental Assistance & Dental Hygiene, Dietetics, Health Education & Administration, Medical Assistance, Medical Technology, Medical Record Administration, Rehabilitation Counseling, Social Work, Nutrition, Occupational Therapy, Physical Therapy, Nursing, Physician Assistance, Psychology, and Recreational Therapy.

The roles and responsibilities required by allied health professionals to meet the needs of persons with disabilities and their families may appear extensive; however, they are not unlike the roles and responsibilities needed for serving any client. It is necessary to recognize the emphasis and implementation of these roles and responsibilities will vary from time to time, determined primarily by the context of one's professional practice, personal motivation and environmental and organizational constraints.

Clearly, the competencies suggested by this list of roles and responsibilities are important for all related health professionals and should not be perceived as limited to those professions which treat children and youth for their handicapping conditions. As indicated earlier, as professionals in the health-care system, all allied health professionals will be expected to possess such competence and, therefore, need to be prepared.

I. TO PROVIDE EFFECTIVE AND COMPETENT SERVICES TO INDIVIDUALS WITH DISABILITIES AND THEIR FAMILIES.

A. To provide effective and competent services for which one is trained; that is:

1. To recognize the indicators of handicapping conditions for severe, mild-moderate, and high-risk children and youth;
2. To provide appropriate screening programs so as to identify children and youth with possible disabilities and make appropriate referral for assessments;
3. To provide appropriate assessments of individuals with disabilities; and
4. To participate in the planning, design, and implementation of programs for individuals with disabilities as appropriate to one's professional concern and practice.

B. To maintain accurate records of assessments, treatments, and progress.

C. To maintain and use current technologies to share information about clients and their conditions (e.g., computer networks).

D. To understand the effects of current treatments on the future performance of the client and to communicate this understanding to parents and clients.

E. To recognize the need for and participate in activities that will ensure continued professional growth and competency:

1. To participate actively in one's professional organization;
2. To advocate for the needs of individuals with disabilities and their families within one's profession;
3. To participate in various activities that will facilitate continuous growth of professional knowledge; and
4. To promote appropriate interdisciplinary training of allied health professionals so as to meet the needs of and ensure the rights of individuals with disabilities.

II. TO DEVELOP AND USE EFFECTIVE COMMUNICATION STRATEGIES.

A. To communicate effectively with individuals with disabilities and their families; that is:

1. To convey information clearly and listen actively to individuals with disabilities and their families;
2. To adapt messages according to the needs of the individual with a disability and his/her family; and
3. To be sensitive to and adapt to the verbal and non-verbal cues which indicate concerns or problems related to the handicapping condition, whether expressed by parents, siblings, or the individual with a disability.

B. To facilitate and effect appropriate inter-professional communication.
C. To facilitate and effect appropriate inter- and intra-agency communication.
D. To facilitate and effect appropriate communication between university/college training programs in allied health, special education, and regular education.
E. To facilitate and effect appropriate communication with and between various state and/or federal agencies and governing bodies.

III. TO RECOGNIZE AND ACCEPT ONE'S PROFESSIONAL RESPONSIBILITIES IN IDENTIFYING, REFERRING, AND ADVOCATING FOR DISABLED YOUNGSTERS AND THEIR FAMILIES; THAT IS:

A. To recognize and accept the needs and rights of disabled youngsters;
B. To understand, implement, and promote methods for identifying appropriate referral sources;
C. To recognize the need to be sensitive to and understand the influence of cultural differences in the identification, referral, and treatment processes;
D. To recognize the prevalent forms of prejudice, stereotyping, and tokenism, and understand how myths and stereotypes contribute to the devaluation of people with disabling conditions;
E. To educate one's self, parents, colleagues, employers, and communities about the needs and rights of individuals with disabilities and their families and the roles the various professionals perform in providing services;

F. To disseminate accurate information to the public concerning:

1. the nature of disabling conditions,
2. the needs and rights of individuals with disabilities,
3. the roles allied health, education, and medical professionals assume in the rehabilitation of disabled individuals, and
4. the qualifications for providing services;

G. To promote and advocate for prevention of disabling conditions (e.g., pre-natal care; genetic counseling, etc.);
H. To help develop and provide cost-effective programs and services;
I. To understand and be able to explain the dimensions and limitations of personal and professional advocacy and its intimate relationship with appropriate identification and referral procedures;
J. To assist in consumer/client and parent involvement in advocacy efforts;
K. To exert pressure for enforcement of existing laws at local, state, and federel levels;
L. To promote regulation, legislation, and litigation on behalf of youngsters and their families;
M. To understand the political process and the implications of advocacy within one's own work setting, community, state, and professional organization;
N. To identify and help implement creative approaches to funding programs for persons with disabilities (including community and business resources and consultants);
O. To improve existing approaches to the delivery of health and education services through research and dissemination; and
P. To help establish and maintain geographical networks to promote access to services in underserved areas (e.g., transportation networks, rural service delivery networks, etc.).

IV. TO UNDERSTAND STATE AND FEDERAL LEGISLATION IN ORDER TO ASSIST FAMILIES IN SOLVING PROBLEMS RELATED TO THE CHILD/YOUTH'S CONDITION; THAT IS:

A. To facilitate children/youth receiving appropriate services;
B. To facilitate parents' understanding of the case management of the child/youth;
C. To facilitate identification of an appropriate case manager;
D. To recognize and provide accurate information to parents;
E. To assist parents in understanding their legal rights;
F. To assist parents in defining and accepting their roles and rights;
G. To promote self-advocacy skills among children and parents;

V. TO HELP COORDINATE EFFORTS OF HEALTH, EDUCATION, AND RELATED SERVICES; THAT IS:

A. To understand other health, education, and related services professionals' roles;
B. To work cooperatively with other professionals concerned with the services provided for children and youth;
C. To promote advocacy initiatives on behalf of youngsters with other professionals;
D. To promote excellence in the quality of service delivery among one's own and others' professions (e.g., eliminate time constraints and scheduling barriers, develop peer review systems);
E. To be sensitive to and actively participate in coordinated and adaptive health-care planning for the life span of the youngsters;
F. To promote interdisciplinary pre-service teaming opportunities (e.g., shared curriculae and field experiences);
G. To promote and, as appropriate, conduct research pertinent to clinical practice;
H. To read and publish in the journals of other disciplines;
I. To help develop effective alliances between various professional organizations and existing parent and consumer coalitions to promote the needs and rights of youngsters with disabilities; and
J. To advocate for funding from appropriate local, state, and federal agencies to train Allied Health professionals.

VI. TO HELP DEVELOP AND/OR MODIFY EDUCATIONAL STANDARDS TO CREATE ACCESS RATHER THAN BARRIERS TO DISABLED INDIVIDUALS WHO WISH TO ENTER THE ALLIED HEALTH, EDUCATION, AND MEDICAL PROFESSIONS.

While some training programs in allied health address these roles and responsibilities, many do not. Leaders within the allied health professions generally recognize the lack of training their students receive to prepare them for meeting their responsibilities for disabled youngsters. As noted above, further substantiation has come directly from allied health practitioners throughout the country. They concur with and reinforce ASAHP's underlying position: related health professionals, including those working in clinical settings, possess (a) special access to children and youth with handicapping conditions; and (b) little, if any, preparation for meeting their roles and responsibilities to assure these youngsters obtain their due educational rights. Hopefully, this document will assist administrators in their efforts to meet the demands of the allied health professional's expanding roles on behalf of persons with disabilities.

In addition, while these roles and responsibilities have been identified specifically for allied health professionals, their relevancy for other professionals who provide services to youngsters with disabilities and their families (e.g., special educators, regular educators, physicians, nurses, etc.) are obvious, and would be well-worth considering as all groups develop and evaluate pre- and in-service education programs. Reactions to the document would be appreciated. Please forward comments and suggestions to: Carolyn M. Del Polito, American Society of Allied Health Professions, One Dupont Circle, Suite 300,

APPENDIX B

AMERICAN SOCIETY OF ALLIED HEALTH PROFESSIONS (ASAHP)

ASAHP is a non-profit professional organization whose membership consists of educational institutions, professional organizations, clinical services and individuals devoted to allied health education, research, and service delivery. Along with over 1,200 individual members, the Society serves and represents a constituency of 22 professional organizations (whose members total approximately 310,000 professionals in related services), and 120 collegiate schools of Allied Health, containing close to 1,000 Allied Health educational programs (graduating approximately 36,500 professionals each year). Statistics from a 1979-80 survey show that graduates of the Allied Health sciences account for as many as 1 out of every 11 graduates from higher education institutions listed by the U.S. Department of Education.

The Society is commited to serving its members' educational interests, especially those of an interdisciplinary nature. Continuing education in special interest areas, particularly in preparing health professionals to meet the needs and rights of persons with disabilities, has been identified by ASAHP members as a priority issue.

The Allied Health Professionals

The population which the Society serves is a heterogeneous group of over 3 million professionals (considerably more than ½ of the nation's total health work force) engaged in diverse health services ranging from relatively high-level and increasingly autonomous health care functions (therapists, technologists, administrators) to supportive ones (assistants, aides) including:

- emergency services (e.g., emergency medical technicians, emergency/disaster specialists, physician assistants);
- reception and screening (e.g., medical or dental secretaries, medical office assistants);
- initial evaluation and diagnosis (e.g., physician assistants, dental hygienists, mental health technologists, medical social workers);
- continued assessment as part of treatment (e.g., physical therapists, occupational therapists, respiratory therapists, speech language pathologists, audiologists, dieticians);
- testing (e.g., medical laboratory personnel, radiologic technologists, ultrasound technical specialists, nuclear medicine personnel, cardiology equipment personnel);
- acute care therapy (e.g., operating room technicians, obstetrical assistants, surgeon's assistants);

- long-term care therapy (e.g., occupational, physical and other therapists; personnel in mental health, social services, counseling, speech language pathology, audiology, nutrition);

- medical instrumentation (e.g., radiation and respiratory therapists, dialysis technicians, cardiopulmonary technicians, ophthalmic dispensers, dental laboratory technicians);

- community health promotion and protection (e.g., nutritionists, dental hygienists, population and family planning specialists, health educators, school health educators, medical librarians, health writers);

- control and elimination of hazards in an institutional or industrial setting (e.g., audiologists, health physicists, health care facilities housekeepers, industrial hygienists);

- education and administration (e.g., deans and directors of colleges and schools of Allied Health, professors at universities and colleges, educators and supervisors of clinical services, administrators and educators of Allied Health professional organizations); and

- research and development (e.g., biomedical engineers, biostatisticians, epidemiologists, toxicologists, public health scientists, and researchers in every occupational category).

Society Resources

As the national organization which represents the broad interests of allied health education, ASAHP stands at the center of a vast network of resources--educational institutions, professional organizations, practitioners, employers, and others--which can be mobilized to bring about changes in education that will improve the quality and cost effectiveness of health care. Because of our national leadership, we are in a unique position to foster efforts by the field toward attainment of the long-range goal espoused by the 1980 Report of the National Commission on Allied Health Education (NCAHE): "a health workforce that meets the service needs of the future effectively, efficiently, and humanely."*

The ASAHP National Office, located at One Dupont Circle in Washington, D.C., houses, along with relevant membership activities, the Center on Allied Health Leadership (recently funded by the Kellogg Foundation), the Center for Continuing Education in Allied Health, and the Allied Health Child-Find and Advocacy Project.

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* National Commission on Allied Health Education, The Future of Allied Health Education, Jossey-Bass Publishers, 1980, p. 65.